Northwest Outlook

hfma washington / alaska chapter
healthcare financial management association

April - June
2008

President's Message

by Greg Moga, President

I always enjoy meeting visitors from other countries, so on July 20th, my wife Mary and I were pleased to host a dinner at our home for Cynthia Cardozo, VP of Finance from the Royal Marsden NHS Cancer Foundation Trust. Cynthia and her family came to visit with Brenda Parnell, the VP of Finance for Samaritan Healthcare in Moses Lake. Cynthia and her husband Narie brought their 3 sons on their adventure to the US and Canada, and we were all impressed when the boys ate every bite of their adult-sized plates of food. Talking about the similarities and differences between the US and UK healthcare systems, and enjoying the boys' energy, made for a great Seattle evening.

Back row-Narie Cardozo, Dayne Clark, Greg Moga
Mid row - Cynthia Cardozo (VP of Finance, Royal Marsden, UK), Brenda Parnell (VP of Finance-CFO, Samaritan Healthcare, WA) , William Cardozo, James Cardozo. Front Row - Seimon Cardozo

If you are interested in the annual HFMA US/UK Exchange, get in contact with Brenda or a past Chapter participant, Libbie Loux. I know that they would love to share their experience with you!

Please update your calendars with 3 dates for the Fall. September 9 is our Chapter's first event co-

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Contributing Writers

Brad Becker
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THANK YOU!!!

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sponsored with the Washington State Healthcare Executives Forum (WSHEF). The networking luncheon and presentation on branding by Amy Davis of the Mayo Clinic will sell out quickly, so get your reservation in right away. September 24-26 is our Fall conference, taking place for the first time at the beautiful Suncadia Resort in Cle Elum. Our room block will go quickly. Next, our educational locale shifts to Alaska for our October 23-24 conference at the downtown Anchorage Hilton.

First-rate educational content and networking with the friendliest finance folks in the healthcare business- that's what you get with the Washington/Alaska Chapter of HFMA!

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Reversing the Trend of Bad Debt

by Bruce Nelson | *SearchAmerica*

Revenue Cycle Management and Hospital Financiers Must Confront This Trend Together in Order to Reap its Rewards.

Yes, bad debt is on the rise everywhere including hospitals. However, you still have the power to decide how to react to this trend. At a high-level, there are two strategies:

A. Wait to see if international healthcare will be adopted by the United States; or
B. Take action to streamline and improve the processes that impact your hospital's bad debt.

Most of us would opt to control our destiny, and adopt strategy B. After all, with industry analysts such as Lehman Brothers reporting that bad debt expenses for hospitals could reach as much as 17%, now is not a good time to sit back and wait.

Unfortunately, there is a stalemate.

Executive Leadership; Limited Purse
In recent years, the direction from many hospital board rooms on how to minimize bad debt was to add more visibility and high-level attention to the revenue cycle side of the organization.

A new position, the Vice President or Director of Revenue Cycle, was created. This executive was tasked with improving the hospital's bottom line by implementing changes and minimizing bad debt by improving collections and patient payment communications, and streamlining its charity care programs – but given a meager budget to do so until s/he demonstrated savings. Unfortunately, changes cannot be achieved with a budget to purchase new systems, enlist alternative collection agencies, train internal staff and more.

When these Vice Presidents approached the board to secure the actual amount of funds necessary to launch the needed changes, the response was most often, *'show us the savings first, and then we'll invest in the plan.'* However, without sufficient budget, significant savings couldn't be demonstrated.

Unfortunately, this game of what comes first – savings or budget – has kept many hospitals at an impass and prevented them from achieving the cost savings they all desired.

Breaking the Impass
As bad debt increases, the cost of doing nothing is high and getting higher. Instead progressive hospitals are breaking this cycle and wisely invest in automating process that will provide payback in 6-12 months.

The following are two strategies that deliver rapid return-on-investment (ROI) and can cut bad debt by 50% or more:

Strategy #1: All Bad Debt Isn't Bad Debt
Too often accounts that are tagged as bad debt, should never have been in the hospital's billing system in the first place. Often 25-50% of bad debt accounts qualify for government programs, such as Medicaid, or the hospital's charity care program but were not screened properly at registration.

This misclassification can cost hospital hundreds of thousands of dollars, if not millions, over time.

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Not only do they negatively impact a hospital's financial health, they also incur collection costs on accounts with little or no chance of payment. This is simply throwing good money away.

By using an automated screening system, hospitals can easily verify whether or not a patient's income and demographics qualifies them for government programs or charity. If done consistently with every patient and at the point of registration, a hospital should never expend resources to collect from these accounts. Instead, those resources can be used to improve collections on the remaining accounts that are collectable.

By removing qualifying charity and government aid accounts from bad debt, a hospital has a healthier balance sheet. By reclassifying bad debt using an automated system to screen for charity accounts, many hospitals can shift 1.7% or more of bad debt to charity by enrolling all qualified patients in their charity care program.

Real-Life Example – Novant Health:

Since automating its screening process, Novant has more than tripled its number of charity cases and experienced a 50% decline in bad debt. For accounts sent out to collections, there is also a greater expectancy for payment as we have validated all contact information and provided the initial income screening for determining the patient's ability to pay.

Lesson 2: Validate Each Patient's Identity & Address

Identify theft is on the rise, especially in healthcare as patients are paying more and more of their hospital expenses. In 2007, Good Morning America did a feature on the apprehension of a Texas ring of individuals who had used false identities to secure hundreds of thousands of dollars of healthcare services from local hospitals. Unfortunately, this case isn't unique.

Every patient entering the hospital must have their identity validated by a third-party service, regardless of their appearance or paperwork. By doing so the hospital can further repel fraud, remain unbiased in their operations, and validate the address to be used for billing purposes.

In 2007, we saw several hospitals use simple identity and address verification to reduce their returned mail by 50% or more. The financial gains were significant and also resulted in lower aging of accounts.

Real-Life Example – Mercy Hospital & Medical Center:

As an urban healthcare provider, Mercy's self-pay patient community is significant. Despite a recent push to have every patient present a valid ID, many patients arrive without proper identification. Mercy knew that with accurate demographics, they could eliminate some of their bad debt that resulted from inaccurate information.

Using a third-party solution, Mercy is able to validate the identity of their self-pay patients by making sure that a patient's date of birth (DOB), Social Security Number (SSN) and the patient's name match. Registrars are able to immediately confirm or correct this patient information within seconds using accurate demographic data.

An increase in accurate patient demographics has led to a reduction in return mail and increased patient satisfaction at Mercy.

Positioned for Greater Tangible Results

Revenue cycle executives and board members are often surprised by the savings their organizations can reap in a short period of time, with some investment in the above strategies. After reclassifying bad debt, and uncovering those accounts that should be allocated to a government aid or the charity care program, they reduce bad debt AND:

- Reduce processing time per charity account by automating the identification and enrollment process.
- Improve collection rates as charity accounts are no longer included.
- Produce more compliant IRS filings (e.g., 501(C)3) to prevent audits.
- Deliver better revenue cycle metrics and ratios:
  - Lower bad debt as a % of revenue
  - % of charity accounts may rise or remain stable, but all charity accounts are assured to fit defined criteria
  - Reduced aging or days in Accounts Receivable, as accounts are moved to charity at the beginning of the process and never

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reach collections

As bad debt rises, the reasons for inaction, and the current stalemates, need to be resolved. This trend is being reversed by hundreds of hospitals across the United States, who have chosen to change instead of wait for change.

Bruce Nelson is Vice President of Sales & Marketing for Search*America.*

My 2008 ANI Experience

by Peggi Ann Rufener, MBA, CCS-P, CCS

I had the pleasure of attending the 2008 ANI recently held in Las Vegas. I served as a Course Coordinator in order to gain some insight to the ins and outs of making 85 or so breakout sessions run smoothly for 3100+ attendees. You see, the 2009 ANI will be held in Seattle in June 2009!! Which means the WA/AK chapter will need many volunteers to help make the 2009 ANI a sweet success.

Outreach Services exhibit at the ANI in Las Vegas.

Volunteering is a way to give back to your community, whether in a professional organization, charitable causes, for youth programs or church, you get the picture. There is a saying out there somewhere that when we volunteer we 'get back x times more'. In my case this is true. The connections I have made through volunteering have helped me professionally and personally. For example, I was the course coordinator for one of the preconference sessions lead by Cheryl Mann. This 3.5 hour session was all about team building. A timely refresher for myself, with some new twists on an important topic. Not only did I walk away with some fresh ideas personally, I also walked away with an idea for a future WA/AK keynote presentation. A double win!

As Course Coordinator, I attended two 3.5 hour preconference sessions, the 3 daily general sessions and a total of six breakout sessions as well as orientation. My day as a Course Coordinator started out early – 7:00 AM on Monday and 6:00 AM the remaining 3 days. Some of the activities were less than glamorous like placing handouts on 3100 chairs, being a roving scanner or securing doors. Other tasks needing attention are opening session announcements, speaker introductions, greeter, scanner, timekeeper and general troubleshooter for AV, A/C and other speaker or room needs. The sessions I coordinated covered a variety of topics.

One of the sessions I had the pleasure of introducing was 'local talent'. Lisa Dodson and David Robbins of Bennett Bigelow and Leedom, PS presented a topic on OIG Activities. While I have heard both of them before, somehow you never get tired of hearing what activities landed someone in hot water. It also makes you ponder a few things you might have on 'autopilot'; Medical Director Fees: – Who authorizes the payments? What is the work product? How are they paid? When are they paid? When was the last time study done? What does the contract say? Then there is the ever hot topic of 'rent' to providers – When was the last time the market was researched? What is the going rate? How much have 'my costs' gone up? What about the ancillary services? As you can see the list can go on forever, but it all circled back to the cost report. Are all of these details being accounted for and reported appropriately? If you don't know the answer then it is time to ask the question(s).

Attending quality continuing education is paramount to our continued professional growth. In these tighter economic times, employers are increasing scrutinizing educational offerings as well as locales. HFMA continues to deliver top notch educational programs in part because of

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your input. For example, you may have attended a conference or seminar and felt the presenter was top notch. You pass along this information and in turn our chapter is able to secure this top notch talent, due to the connections that you made.

HFMA's new Chairman of the Board, Robert L. Broadway, FHFMA, theme for 2008-2009 is *Making Connections*. By volunteering part of your valuable time, you are making connections on both professional and personal levels. These connections will no doubt help you grow in your professional and personal development. Please consider what you can do when we ask for 2009 ANI volunteers! There will be many tasks, large and small, behind the scenes and front and center. I am confident we can match your time and skill with a worthy task! ■

Linking Executives and Physicians to the Success of the Organization

by Dan Gaffney | Moss Adams LLP

Strategic planning is the cornerstone for building a successful organization. Simply put, strategic planning is a process for making good decisions about your organization's future.

To be successful, the organization's strategy must meet the physicians' and executives' personal goals. These goals may include funding retirement, maintaining and building a lifestyle, addressing the need for control and security, creating a sense of place, and being part of a successful organization. Strategic plans that fail to consider the executives and physicians personal goals can create conflict within the organization, particularly when egos are involved.

As you strategically look at your organization and its continued success and future growth, developing a comprehensive plan that links the executives and physicians to the healthcare organization will have significant benefits.

One of the ways to link the two together is to develop a comprehensive personal financial planning program for the executives and physicians in your organization. Providing your executives and physicians with information and education about their own personal financial circumstances allows the organization to accomplish several things.

First, peace of mind that your executives and physicians have been given solid education about their personal finances, which allows them to focus less attention on their personal financial needs and more attention on serving patients.

Second, it will give the organization the ability to tie its strategic plan to its human capital plan (recruiting, retention, compensation, etc.). You will have a higher degree of confidence that your executives and physicians are adequately preparing their personal finances, allowing you better understanding of when they may be retiring and thus what your recruiting needs are. Personal financial planning is the cornerstone for achieving financial independence and security and offering this to executives and physicians is another tool to use to differentiate your organization as a great place to work and one that cares about the success of its people.

Third, as you continuously plan for the organization's succession (physician, CEO, CFO, and board member retirements and transitions) which relates directly to its ability to succeed in the future, you can have a high degree of confidence that those with control over the success of the organization have taken proper financial planning steps to allow them to focus on patients and making the organization successful.

In an increasingly competitive environment for talented people, organizations that focus on linking personal success with the success of the organization and that focus on differentiating itself as a great place to work will have the competitive advantage that will propel it to long-term success.

Dan Gaffney has been in public accounting since 1996. He is the co-chair of the Firm's Wealth Services Industry Group and serves on the group's Steering Committee. He deals primarily with tax issues, strategic and operational business planning, estate planning, retirement planning, and business succession planning.
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The Interplay Between Hospital Liens and Health Insurance, Medicaid or Medicare

by Christina Gamache | Outreach Services

I. Introduction

Even in the absence of an express contract, the rendering of medical services creates an implied contract between the hospital (or other health care provider) and its patient, resulting in a creditor-debtor relationship. Unlike most other creditors, however, hospitals must often provide services without first ascertaining whether the patient can pay. This is virtually always the case where a patient is injured in an accident and requires emergency care.

In an attempt to lessen the burden imposed on hospitals that provide care to injured patients, many legislatures have enacted hospital lien statutes (sometimes called physician's liens). Lien statutes give the hospital a lien upon recoveries the patient might receive to compensate for his or her injuries.[2] Lien statutes do not change the fact that the patient is still responsible for paying his or her bill. However, by granting the hospital a security interest in any settlement, judgment or other money paid to the patient on account of his injuries, lien statutes provide a mechanism for the hospital to ensure its bill will be satisfied in whole or in part out of those funds.

Questions often arise regarding the enforceability of a hospital lien after the hospital has received a discounted payment for its services from a patient's health insurance company, Medicare or Medicaid. This article will address the effect of those payments on hospital liens and suggest steps a hospital can take to increase the chance that its lien rights will be protected, thereby maximizing potential recoveries.

II. Hospital Liens and Health Insurance

If a patient has health insurance that pays a portion of the patient's medical charges, the hospital's ability to enforce a lien for the difference between the insurance payment and the hospital's actual charges will depend upon whether there is a provider agreement and the terms of that agreement.

In the absence of a provider agreement, the hospital is generally free to enforce a hospital lien in addition to (or instead of) seeking reimbursement from the health insurance company.[3] Where there is a provider agreement, the hospital can only enforce a lien if consistent with the language of the agreement. As a general rule, a hospital lien will not be allowed if the provider agreement simply states that negotiated rates must be accepted by the hospital as "payment in full." However, if the provider agreement allows recovery in excess of the negotiated insurance rate from other sources, it is more likely that the hospital's lien rights will be enforced. To facilitate protection of lien rights, hospitals can attempt to include language that expressly allows recovery in excess of the negotiated insurance rate from third party payers and makes reference to lien rights in provider agreements.

1. "Payment in Full" Provisions

Within the health insurance industry, it is common for insurers and medical providers to enter into agreements in which the provider agrees to accept as full payment an amount less than what is billed to the insured patient. In exchange for the provider's agreeing to offer its services at a discounted rate, the insurer agrees to create incentives for its insureds to use the provider, thus helping to ensure a higher volume of patients for the provider. If the provider agreement contains a "payment in full" provision or prohibits the hospital from balance billing the patient and says nothing about third party payers

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or lien rights, the hospital will generally not be entitled to assert a hospital lien. The rationale behind this rule is that once a patient's health insurance has paid, no debt is owed from the patient to the hospital. In the absence of a debt, there can be no lien.

To illustrate, in N.C. v. A.W[4] the patient was treated at Northern Illinois Medical Center (NIMC) following an automobile accident. Although the patient's medical bills totaled $22,551, plaintiff's health insurer paid NIMC an agreed rate of $4,200 as "payment in full" pursuant to NIMC's network contract with One Health Plan of Illinois, Inc. (One Health). The contract between NIMC and One Health provided that after payment by the insurer, NIMC could only bill a member for deductibles, coinsurance, copayments, and charges for non-approved or non-covered services.

In a subsequent action to determine the validity of a hospital lien filed by NIMC against the proceeds of a third party liability settlement (stemming from the automobile accident), the court held that the lien was not enforceable. The court stated that in order for a hospital lien to attach, there must be a debt owed from the patient to the hospital. Because the provider agreement between NIMC and One Health extinguished all debts when the patient's health insurer paid NIMC at the agreed rate, no lien could attach.

A similar conclusion was reached in the more recent case of Parnell v. Adventist Health System.[5] There, the patient was injured in an automobile accident and treated at San Joaquin Community Hospital (owned and operated by defendant Adventist Health System/West). The court held that where a hospital accepts a contractually agreed upon reduced rate from the patient's health insurer as "payment in full" under a provider agreement, the hospital cannot assert a hospital lien against a potential damage recovery from a third-party tortfeasor. The court reasoned that acceptance of the payment in full from the health insurer extinguishes the plaintiff's obligation to the hospital and, thus, removes any basis for the assertion of the hospital lien.[6]

2. Negotiated Lien Rights

Because most provider agreements prohibit hospitals from charging patients for services covered by the agreement, hospitals cannot avoid the effect of "payment in full" provisions by simply choosing not to bill a patient's health insurance company.[7] However, hospitals can attempt to negotiate provider agreements that allow them to enforce hospital liens even when they have negotiated reduced-rate payments from health insurance payers. The court in the *Parnell* case recognized this alternative:

> By precluding the Community Hospital from asserting a lien under the [Hospital Lien Act] in this case, we "simply give[ ] effect to" its contracts. . . . If hospitals wish to preserve their right to recover the difference between the usual and customary charges and the negotiated rate through a lien under the [Hospital Lien Act], they are free to contract for this right. Our decision today does not preclude hospitals from doing so.[8]

Several courts have addressed the type of language that may protect a hospital's ability to enforce its lien rights. For example, in *Rogalla v. Christie Clinic*,[9] the patient suffered injuries in an auto accident and was treated at Christie Clinic, P.C. The patient had health insurance through an HMO that had entered into a medical services/ capitation agreement with Christie Clinic. Following the patient's settlement with the at-fault party in the auto accident, the Court held that Christie Clinic could enforce a Physician's Lien against the settlement proceeds based on the following language contained in the medical services agreement: "Christie and PersonalCare shall have the right to seek to recover charges incurred as a result of providing Medical/Hospital Services which are the liability of a third party."

In *Andrews v. Samaritan Health System*,[10] the Court also held that hospitals may enforce medical liens against patients' tort recoveries

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where provider contracts contained language to that effect. In that case, the provider contracts each contained language stating that the hospitals accepted the plaintiffs' insurer's payment as "payment in full." However, the contracts also reserved the right of the hospitals to recapture from third party payers the difference between any payments made by the insurer and the providers' customary charges. The Court held that this reservation clearly qualifies the "payment in full" language and sets forth the hospitals' expectation to recover their customary charges when possible.

Finally, in Richmond v. Caban,[11] the patient was injured in an automobile accident and incurred $24,238 in medical expenses at Copley Memorial Hospital (Hospital). Knowing it would receive less than one-third of the value of its services if it submitted a claim to the patient's HMO policy, the hospital instead attempted to maximize its recovery by filing a lien against the patient's settlement proceeds. The court found that while the hospital could bill the HMO, it was not obligated by the provider agreement to do so prior to enforcing a hospital lien. The court based its finding on language in the agreement that provided that the hospital would first seek payment from the third party insurer and then recover any additional amounts allowed under the provider contract from the insurer (i.e. the difference between the amount allowed under the provider agreement and the amount paid by the tortfeasor). Ultimately, however, the Court held that an indemnity provision contained in Illinois' HMO Act limited enforcement of the lien to (1) applicable co-payments or deductibles or (2) fees for services not covered by the policy.

The foregoing authorities indicate that lien rights may be protected where the provider agreement includes language that allows the hospital to recover payments from third party payers, including tortfeasors and their insurers, in excess of the negotiated insurance rate. A payer's ability and willingness to enter into such an agreement will depend, at least in part, on its existing member contracts and any limitations imposed by such contracts. If a payer is willing to include language protecting lien rights in its provider agreement, the agreement should clearly state that both parties contemplate an exception to any "payment in full" language and should make specific reference to enforcement of hospital liens.

III. Medicare and Medicaid

If a hospital accepts a payment from Medicaid or Medicare for medical services rendered to a patient, the law is well-settled that the hospital may not also enforce statutory lien rights.[12] The rationale behind this rule can be found both in the language and intent of the Medicaid and Medicare programs. Federal Medicaid regulations clearly mandate that states must require providers to accept Medicaid payments as payment in full.[13] This language prevents providers from billing any entity for the difference between their customary charge and the amount paid by Medicaid. Similarly, a hospital that participates in the Medicare program is termed a "participating provider".[14] To be a participating provider, the hospital must enter into an agreement with Medicare.[15] The first requirement of the agreement is that the provider promise "not to charge ··· any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter ····" [16]

The mere fact that a patient is eligible for Medicaid or Medicare does not, however, preclude a hospital from asserting a hospital lien. There is authority that indicates that a hospital can elect to refuse a Medicaid payment and instead choose to pursue a hospital lien. In *Evanston Hosp. v. Hauck*, the court stated:

> . . . Evanston Hospital was not "forced" to abandon its right to sue Hauck; no one coerced the hospital into cashing a $113,424 [Medicaid] check from the taxpayers as partial reimbursement for Hauck's medical bills. Rather, the hospital could have simply forsaken Medicaid and taken its chances that Hauck would somehow come up with the money to pay the bills himself.[17]

However, as the Evanston case makes clear, the decision to pursue a hospital lien in lieu of accepting a Medicaid payment must be made

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before the Medicaid payment is accepted by the hospital. In other words, the hospital cannot cash a Medicaid payment and then wait until after a third party action against a tortfeasor is resolved to decide whether or not the Medicaid payment or its hospital lien would be more lucrative.

A similar choice must be made between billing Medicare and pursuing potential third party liability. When a hospital has reason to believe that it has provided services to a patient for which payment under liability insurance may be available, Medicare rules require that the hospital only bill the liability insurer during the first 120-days after services have been provided unless there is evidence that the liability insurer will not pay within the time period. After the 120-day timeframe has ended, the hospital may, but is not required to, bill Medicare for conditional payment if the liability insurance claim is not resolved. If the hospital chooses to bill Medicare after the 120-day period and is paid, it must withdraw all liens against the liability insurer and the patient's settlement. The Medicare reimbursement must be accepted as payment in full and the hospital may charge the beneficiary only for applicable deductible, coinsurance, and non-covered services.[18]

Endnotes:

[1] Chris Gamache serves as in-house Corporate Counsel for Outreach Services and is a member of Moga Law Group, PLLC.
[2] The scope of lien statutes varies from state to state. Some statutes only create a lien on funds paid by tortfeasors or their insurers, while other statutes create a lien on any claims that the patient may have on account of the patient's injuries.
[3] An exception to this rule would, of course, exist if the health insurance company conditions payment to the hospital on an agreement by the hospital to accept the payment as "payment in full."
[4] N.C. v. A.W, 305 Ill.App.3d 773, 713 N.E.2d 775 (1999).
[5] Parnell v. Adventist Health System, 35 Cal.4th 595, 109 P.3d 69, 26 Cal.Rptr.3d 569 (2005).
[6] See also, Satsky v. US, 993 F.Supp. 1027 (SD Tex. 1998)(no lien allowed where hospital agreed to accept payment from insurer as payment in full, thereby extinguishing debt from patient.)
[7] In Dorr v. Sacred Heart Hospital, 228 Wis. 2d 425, 597 N.W.2d 462 (Wis. App. 1999), the court held that a hospital lien was unenforceable even though the hospital elected not to bill the patient's HMO insurer. Both the HMO statute and the provider agreement prohibited the hospital from charging its patients for services covered by the terms of the group contract. As such, there was no debt owed by the patient to which a hospital lien could attach.
[8] Parnell v. Adventist Health, supra, 35 Cal.4th at 611. See also, Lopez v. Morley, 352 Ill.App.3d 1174, 1181, 817 N.E.2d 592, 599 (2004)("A hospital's ability to preserve its lien rights lies within its own hands. If a hospital contracts in such a manner that a debt survives, then the lien will survive also.")
[9] Rogalla v. Christie Clinic, 394 Ill. App. 3d 410, 794 N.E.2d 384 (2003).
[10] Andrews v. Samaritan Health System, 201 Ariz. 379, 36 P.3d 57 (Ariz. App. 2001), disapproved on other grounds in Blankenbaker v. Jonovich, 205 Ariz. 383, 71 P.3d 910 (2003).
[11] Richmond v. Caban, 324 Ill. App. 3d 48, 754 N.E.2d 870 (2001).
[12] Spectrum Health Continuing Care Group v. Anna Marie Bowling Revocable Trust, 410 F.3d 304 (6th Cir. 2005); Evanston Hospital v. Hauck, 1 F.3d 540 (7th Cir. 1993); Rybicki v. Hartley, 792 F.2d 260 (1st Cir. 1986). See also, Mallo v. Pub. Health Trust of Dade County, 88 F.Supp.2d 1376 (S.D.Fla. 2000); Holle v. Moline Pub. Hosp., 598 F.Supp. 1017 (C.D.Ill. 1984).
[13] 42 CFR 447.15.
[14] 42 C.F.R. 489.2(b).
[15] 42 U.S.C. 1395cc; 42 C.F.R. § 489.11.
[16] 42 U.S.C. 1395cc(a)(1)(A).
[17] Evanston Hospital v. Hauck, 1 F.3d 540, 542 (7th Cir. 1993).
[18] See, http://www.cms.hhs.gov/ProviderServices/08_nofaultandliabilityinsurance.asp.

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Job Opportunities

TITLE	ORGANIZATION	LOCATION	CONTACT
Audit Manager	CHAN	Longview, WA	krandall@chanllc.com
Billing Manager	Outreach Services	Spokane, Washington	dmgordon@cbosolution.com
CFO	Benefis Hospitals	Great Falls, MT	ZReynolds@qlksearch.com
CFO	Ernest Healthcare	Post Falls, ID	tclarke@mrigreenville.com
Client Executive of Patient Financial Services	Perot Systems Corporation	Renton, WA	Angela.Haynes@ps.net
Director of Finance	Providence Health Care	Eastern Washington	OzustD@shmc.org
Director of Professional Revenue Cycle	Stanford Hospital & Clinic	Stanford, CA	chmcguire@astound.net
Finance Manager	The Poly Clinic	Seattle, WA	joe.shields@Polyclinic.com
Financial Analyst	Franciscan Health System	Tacoma, WA	LanceBabb@fhshealth.org
Financial Analyst	Franciscan Health System	Tacoma, WA	LanceBabb@fhshealth.org
Financial Analyst	Providence Everett Medical Center	Everett, WA	heidi.miller@providence.org
Manager Financial Reporting & Accounting	Harrison Medical Center	Bremerton, WA	TracyBarton@harrisonmedical.org
Manager-Insurance & Managed Care Contracting	Salem Hospital	Salem, OR	amyl.schmidt@salemhospital.org
Financial Analyst II	Salem Hospital	Salem, OR	amyl.schmidt@salemhospital.org
Financial Analyst III	Salem Hospital	Salem, OR	amyl.schmidt@salemhospital.org
Sr. Financial Analyst	Northwest Medical Specialist	Tacoma, WA	churley-paneiro@nwmsonline.com
Staff Accountant	Island Hospital	Anacortes, WA	swhitelock@islandhospital.org
VP Finance-CFO	St. Joseph Regional Medical Center	Lewiston, Idaho	nowens@sjrmc.org

For more information on these listings or to include a listing, please contact Kimie Delos Reyes at (503) 507-6271 or mailto:kimie@hawesfinancial.com

See also National HFMA's website (www.hfma.org) for additional job listings.
[Last Update: July 2008]

Would you like to check your progress toward a Founders Merit Award?

Individual scoring records for the Founders Merit Award program are maintained for chapter members by LCC Council III.

To receive a copy of your record, please contact

Tom Muller

Telephone: (360) 459-8994 • Email: tjwashington@reachone.com

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SEE YOU THERE!

Certification Maintenance. . . . . .

by Brad Becker

Here is another reason to attend a HFMA chapter meeting! Along with great educational sessions and networking opportunities, chapter meetings provide necessary education hours for certification maintenance. Along with your CPA or other designation, don't forget that HFMA certification (as either a CHFP or FHFMA) also requires ongoing education hours.

Per the HFMA requirements: "The HFMA Board of Directors requires that all CHFPs and FHFMAs complete continuing education activities to demonstrate they are maintaining their technical and professional competence." This evidence for designation is due to National every three years. Failure to meet the maintenance requirements by May 31st of your "third year" will result in removal of the designation. The designation will then need to be re-earned by successfully completing the requisite exams.

The continuing education requirements are as follows:

- 90 contact hours total in eligible programs over the three-year period.
- A minimum of 20 contact hours per maintenance reporting year.
- A minimum 50% of the total contact hours (45 hours) must be in healthcare finance. The remaining contact hours may be from attending other eligible programs and professional activities. A listing of all eligible programs and activities is available at www.hfma.org/certification/certmaintenance/.

As a reminder, HFMA National maintains a listing of National programs you have attended (e.g., ANI, National Clusters, etc). Each member is responsible for reporting their own chapter and other education hours to National. The certification site above has directions for reporting your educational sessions.

Prior to the end of your three-year education period, National HFMA will send out a reminder E-mail on your certification hours. Don't get caught up in a reporting or training scramble. Keep up-to-date on your education hours!

Your next opportunities to earn local chapter education hours are:

- September 24th – 26th at Suncadia Resort in Cle Elum, Washington.
- October 23rd – 24th at the Hilton in Anchorage, Alaska.

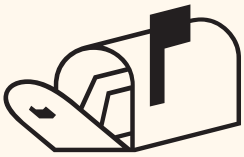
Tom Muller is One of 12 HFMA Members Awarded Chapter Life Membership!

Awarding chapter life membership is a great way to recognize significant contributions made by individual chapter members. Congratulations to the 2007-08 approved chapter life members: Thomas A. Kliebert (Louisiana Chapter), John H. Traut (Nevada Chapter), Bob E. Duncan, FHFMA (North Carolina Chapter), C. Edward Schweitzer, FHFMA (Southwestern Ohio Chapter), William E. Baecker (Southwestern Ohio Chapter), Joe A. Arro (Southern Illinois Chapter), Janice E. McGinness (Southern Illinois Chapter), Trudy Solomon (South Carolina Chapter), Allan Gearig (Western Michigan Chapter), Pat Horan (Western Michigan Chapter), and Wade Nitz (Western Michigan Chapter), and Thomas E. Muller, FHFMA (Washington/Alaska Chapter).

Presidents need to submit names by June I Oth to HFMA's Director of Member Services. For more information visit the Chapter Life Membership area on the website.

$100

You could win $100 by writing an article for N.W. Outlook! Share your knowledge & experiences with other HFMA Members. You can help make a difference!



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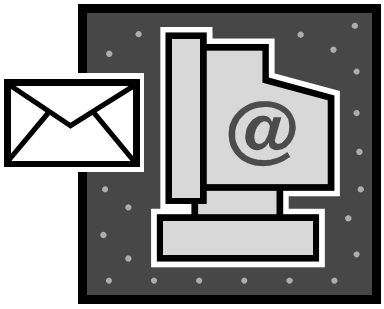
How Do I Change My HFMA Information?



All of our chapter directory information including e-mail and addresses for the newsletter are received from the National HFMA database.

The easiest way to make changes is via the internet. Simply follow these steps to change any of your personal information.

1. **Log on to http://www.hfma.org**
2. **Go to the membership section**
3. **Log in using the username and password prompts**
4. **Follow instructions to access your Profile**
5. **Edit information.**

New Members

The Washington/Alaska Chapter is pleased to announce the following new members:

Michael Albainy
Apollo Data Technologies

Kristyn Andrews
Providence Health and Services

Paul Babcock
Central Washington Medical Group

Kerri Baer
Evergreen Financial Services Inc

Lynn Barnhart
UW Medical Center

David Batistich
Professional Credit Service

Lloyd Beemer
Providence Health and Services

Chris Coates
The Doctors Clinic

Michael Crawford
Commerce Bank

Evelyn Daniels
Recondo Technology

Peter Devore
CHAN Healthcare Auditors

Jerri Dion
Lake Chelan Community Hospital

Rachel Dobrow Stone
Davis Wright Tremaine LLP

Kimberley Flick
Southwest Washington Med Center

Karl Fritschel
Providence Health & Services

Craig Gonzales
St. Jude Medical

Girish Hagan

Sara_Elizabeth Hyre
Clark Nuber

Shari Johnson
Southwest Washington Med Center

Justin Jorgensen
Columbia County Health System

Jim Kimbrell
Columbia Ultimate

Joyce Kobayashi
Providence Health and Services

Michael Langford
Red Cedar Partners LLC

Karen Libby
Providence Health and Services

Cecilia Lu
Virginia Mason Medical Center

Carolyn Marks
Snoqualmie Valley Hospital

Chuck McKeirnan
Overlake Hospital Med Center

Jason Mitchell
Providence Health & Services

Eve Peabody
Seattle Cancer Care Alliance

Martha Rodriguez
Sunnyside Community Hospital

Christine Santos

Helene Schultz
Overlake Hospital Medical Center

Robert Smith
Revenue Cycle Consultants (RCC)

Sherry Smith
Yukon Kuskokwim Health Corporation

Ben Stokes
Heartland Partners, LLC

Grace Tran
Providence Health & Services

Sidonie Turner
HealthServices NW

Vickie Visculgia
YCCS - A National Collection System

Joe Wanner
Samaritan Healthcare

Diane Watters
United General Hospital

Llew Werner

Michael Westlund

Deborah Williams
HealthServicesNW

Get Connected!

Upcoming Chapter Meetings

DATE	EVENT	LOCATION
September 9, 2008	HFMA / WSHEF Joint Presentation	The Ranier Club, Seattle, WA *or* Virginia Mason, Seattle, WA
September 24-26, 2008	HFMA Fall Workshop & Meeting	Suncadia Resort, Cle Elum, WA
October 23-24, 2008	HFMA Alaska Meeting	Hilton, Anchorage, AK
Nov/Dec 2008	HFMA One Day Workshop	Tukwila, WA

www.waakhfma.org

Have a great summer!

from your Washington - Alaska HFMA Chapter Board Members

NW Outlook

April - June 2008

Published bi-monthly by the Washington / Alaska Chapter of HFMA

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